Agenda Item No: 7

Cambridgeshire and Peterborough Fire Authority

Internal Audit Progress Report

1 October 2020

RSM

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1 Key messages

This report below provides a summary update on progress against each plan and summarises the results of our work to date. Those reports finalised since the last Committee are highlighted in **bold** below. (Two reports were finalised prior to the last Committee, but not presented due to an admin error, therefore have been included within this paper for completeness)

Progress against the internal audit plan 2020/21

Assignment	Status / Opinion issued	Actions agreed			Opinion Issued
		L	M	H	
Fleet Management – Policies and Procedures (1.20/21)	**FINAL REPORT**	**0**	**2**	**0**	**Advisory**
Governance – Fire Authority (2.20/21)	**FINAL REPORT**	**2**	**2**	**0**	**Reasonable Assurance**
Procurement – Proactive Processes (3.20/21)	**FINAL REPORT**	**0**	**4**	**0**	**Reasonable Assurance**
Risk Management (4.20/21)	**FINAL REPORT**	**4**	**4**	**0**	**Reasonable Assurance**
Key Financial Controls	Planned - 5 October 2020				
People Strategy	Planned - 1 February 2021				
Follow up	Planned - 1 February 2021				
Estates and Property Maintenance	Planned – 24 February 2021				

Appendix A – Other matters

Annual Opinion 2020/21

The Overview and Scrutiny Committee should note that the assurances given in our audit assignments are included within our Annual Assurance report. The Committee should note that any negative assurance opinions will need to be noted in the annual report and may result in a qualified or negative annual opinion.

Changes to the audit plan

Since the last Overview and Scrutiny Committee we have been requested to delay the audit review of Estates and Property Maintenance audit due to the impact of COVID-19 on the department and the resources available from the team. This has now been re-scheduled for February 2021, previously October 2020.

Information and briefings

There has been four Emergency Services client briefing issued since our last Committee.

- Audit & Risk Committee – Navigating COVID-19
- Emergency Services New Briefing – September 2020

Quality assurance and continual improvement

To ensure that RSM remains compliant with the IIA standards and the financial services recommendations for Internal Audit we have a dedicated internal Quality Assurance Team who undertake a programme of reviews to ensure the quality of our audit assignments. This is applicable to all Heads of Internal Audit, where a sample of their clients will be reviewed. Any findings from these reviews being used to inform the training needs of our audit teams.

The Quality Assurance Team is made up of; the Head of the Quality Assurance Department (FCA qualified) and an Associate Director (FCCA qualified), with support from other team members across the department. This is in addition to any feedback we receive from our post assignment surveys, client feedback, appraisal processes and training needs assessments.

Appendix B – Executive summaries and action plans (High and Medium only) from finalised reports

EXECUTIVE SUMMARY – FLEET MANAGEMENT (POLICIES AND PROCEDURES)

With the use of emails for the transfer of information, and through electronic communication means, remote working has meant that we have been able to complete our audit and provide you with the advisory report agreed. It is these exceptional circumstances which mean that 100 per cent of our audit has been conducted remotely.

Why we completed this audit

We undertook an advisory review of the policies and procedures in place relating to fleet management, to review the control framework in place to mitigate against key-person dependency risk. Fleet management covers the maintenance of all vehicles owned by the Service, including both fire appliances and other light service vehicles. As part of the audit we reviewed the following plans, policies and procedures:

- Fleet Asset Management Plan;
- Use of Service Vehicle;
- Vehicle Maintenance;
- Fleet Safety Whilst Travelling;
- Vehicle Log Books;
- Collision, Vehicle or Third Party Damage, or Theft; and
- Pool Vehicle.

Conclusion

Our review found that policies and procedures were in place and included key information. However, we identified weaknesses relating to the absence of a gap analysis to ensure that all required policies and procedures have been identified, as well as issues with the approval and independent review of existing fleet management policies and procedures.

Key findings

We identified the following weaknesses:

Fleet Management Gap Analysis

We were informed by the Head of Fleet and Equipment Services that a gap analysis had not been performed to confirm that all required policies or procedures relating to fleet management had been identified. This includes the assessment of roles and responsibilities in relation to fleet management and ensuring back up controls are in place to mitigate against key-person dependency risk. There is a risk that there is insufficient guidance in place for

fleet management which could mean staff do not follow approved and consistent processes.
There is also a greater chance of key-person dependency risk materialising, resulting in controls not being effectively applied. As such, we have agreed a medium priority action to undertake a gap analysis of fleet management. **(Medium)**

Fleet and Transport Asset Management Plan and Associated Policies and Procedures

The organisation has a Fleet and Transport Asset Management Plan in place. We were informed by the Head of Fleet and Equipment Services that the Fleet and Transport Asset Management Plan and the suite of policies and procedures had been approved by the Area Commander, however, these approvals had not been documented. There is a risk that staff are following inappropriate guidance.

We also noted that the Fleet and Transport Asset Management Plan and the associated policy and procedure documents did not state the date of last and next review. There is a risk that guidance available to staff will become outdated and inconsistent with current practice and/or legislation.

In light of both findings, we have agreed a medium priority action to review, update with most recent and next review dates and approve the policies and procedures. **(Medium)**

We noted the following controls to be adequately designed and operating effectively:

Fleet Management Policy and Procedure Content

Through review of the fleet management policies and procedures we found they included key information, such as:

- fire appliances, when they may be used and roles and responsibilities for who may approve their use;
- maintenance and checks on service vehicles including who issues should be reported to;
- when it is appropriate to don protective equipment within a service vehicle and relevant speed limits;
- how to complete a vehicle's log book and who is responsible for maintaining them;
- who to report a vehicle collision, damage or theft to and what occupants must do in the event of a collision; and
- how to book a pool vehicle and ensuring the most efficient use.

Training and Succession Planning

We were informed by the Head of Equipment and Fleet Services that training and succession planning had not been established yet as retirement of key personnel in the function was not planned to take place in the short term. We were also informed that training and succession planning will be prepared in preparation for the Head of Equipment and Fleet Services retirement. As such, we have not raised an action in relation to this finding as it is a known area required in the future.

2. DETAILED FINDINGS AND ACTIONS

This report has been prepared by exception. Therefore, we have included in this section, only those areas of weakness in control or examples of lapses in control identified from our testing and not the outcome of all internal audit testing undertaken.

1. Fleet management gap analysis				
Control	A gap analysis has not been undertaken to identify which policies or procedures are required for the effective management of the organisation's fleet.		**Assessment:** **Design** × **Compliance** N/A	
Findings / Implications	We were informed by the Head of Fleet and Equipment Services that a gap analysis had not been performed with the purpose of identifying any policies or procedures that may be required for fleet management. This includes the assessment of roles and responsibilities in relation to fleet management and ensuring back up controls are in place to mitigate against key-person dependency risk. As such, there is a risk that there is insufficient guidance in place for fleet management which could mean staff do not follow approved and consistent processes. There is also a greater chance of key-person dependency risk materialising, resulting in controls not being effectively applied.			
Management Action 1	The Area Manager will undertake a fleet management gap analysis to identify which policies or procedures are required to manage the area. This will include assessing which staff / officers will be assigned key fleet management roles and responsibilities, as well as the identification of back up controls to prevent key-person dependency risk.	**Responsible Owner:** Chris Parker, Area Manager	**Date:** 31 December 2020	**Priority:** Medium

2. Key documentation – Approval, review and availability				
Control	There is a Fleet and Transport Asset Management Plan in place which was approved by the Area Commander. The Plan includes key information such as: • a breakdown of vehicles owned; • expected vehicle life cycles; • vehicle procurement guidelines; • maintenance of vehicles;		**Assessment:** **Design** × **Compliance** -	

2. Key documentation – Approval, review and availability	
	• disposal of a vehicle; • fleet financial planning; and • roles and responsibilities or the Transport department in monitoring and maintaining the fleet. The Plan has been made available to staff within each service vehicle and via the Service's intranet. Following the most recent update, the Plan has not been distributed to staff. The organisation also has a suite of supporting policies and procedures in place which are available to staff via the organisation's intranet: • Use of Service Vehicle; • Vehicle Maintenance; • Fleet Safety Whilst Travelling; • Vehicle Log Books; • Collision, Vehicle or Third Party Damage, or Theft; and • Pool Vehicle. All documentation is subject to regular review but the dates of last and next review are not documented.
Findings / Implications	Approval We were informed by the Head of Fleet and Equipment Services that the Fleet and Transport Asset Management Plan and the suite of policies and procedures had been approved by the Area Commander, however, this approval had not been documented. Whilst we understand this, as we were unable to evidence that the Plan and other policies and procedures had been approved, there is a risk that staff are following inappropriate guidance. Review We also noted that the Fleet and Transport Asset Management Plan and the associated policy and procedure documents did not state the date of last and next review. We were informed by the Head of Fleet and Equipment Services that each document would be reviewed and updated when a new appliance was purchased with any resulting changes in guidance. We were also informed that where a new appliance was not purchased, the documents would be reviewed annually. Whilst we understand this, if previous and next review dates are not recorded on policy and procedure documents, there is a risk that guidance available to staff will become outdated and inconsistent with current practice. Availability We were informed by the Head of Fleet and Equipment Services that policies and procedures relating to fleet management are stored within service vehicles. Due to the COVID-19 lockdown in place at the time of the audit, in May 2020, we were unable to confirm this. We confirmed through review of a screenshot of the Service's intranet that the following policies and procedures had been made available to staff:

2. Key documentation – Approval, review and availability				
	• Fleet and Transport Asset Management Plan; • Vehicle Maintenance Policy; • Fleet Safety Whilst Travelling Policy; • Collision, Vehicle or Third Party Damage, or Theft Procedure; and • Pool Vehicle Procedure. However, we noted through review of the screenshot that the Use of Service Vehicles and Vehicle Log Books Policies had not been made available to staff. We were also informed by the Head of Fleet and Equipment Services that they were unsure whether the policies had been distributed to staff following the most recent update. There is a risk that staff are unaware of the current fleet management guidance.			
Management Action 2	The Area Manager will ensure that the Fleet and Transport Asset Management Plan and associated policies and procedures are reviewed, updated with most last and next review dates, and presented to an appropriate senior member of staff or meeting group for approval. This will be recorded within minutes, where appropriate, and on the policies and procedures. Following this, updated copies will be distributed to staff via email and to all service vehicles and uploaded to the intranet.	**Responsible Owner:** Chris Parker, Area Manager	**Date:** 31 December 2020	**Priority:** Medium

EXECUTIVE SUMMARY – GOVERNANCE FIRE AUTHORITY

With the use of emails for the transfer of information, and through electronic communication means, remote working has meant that we have been able to complete our audit and provide you with the assurances you require. It is these exceptional circumstances which mean that 100 per cent of our audit has been conducted remotely. Based on the information provided by you, we have been able to undertake our sample testing.

Why we completed this audit

We have reviewed the governance arrangements in place at the Authority to assess whether the groups within the governance structure are effectively discharging their duties. The Authority has eight Committees in place in total and these are:

- Fire Authority
- Policy and Resources Committee;
- Overview and Scrutiny Committee;
- Performance Review Committee;
- Appointments Committee;
- Fire Authority Discipline Committee;
- Fire Authority Appeals Committee; and
- Appeals (Pension) Committee.

The Fire Authority consists of 17 elected members who are Councillors from Cambridgeshire County Council (CCC) and Peterborough City Council (PCC). A consultation meeting of members and officers of the Fire Authority was held remotely in March 2020, as a result of the restrictions imposed due to the coronavirus pandemic. In response to the pandemic, the Authority, going forward, will be required to cover the remit for the Fire Authority, Policy and Resource Committee and Overview and Scrutiny Committee. The Authority had initially scheduled two meetings each for both the Policy and Resources Committee and the Overview and Scrutiny Committee between the months of January and June 2020, however these were all cancelled due various reasons including the restrictions imposed by the pandemic.

As part of this audit, we have reviewed the last three minutes and papers for the Fire Authority (June 2019, November 2019 and February 2020); Policy and Resource Committee (July, October and December 2019); Overview and Scrutiny Committee (January, May and October 2019); and Performance and Review Committee (October 2019, December 2019 and March 2020).

The remaining subcommittees meet as and when required, we were advised by the Scrutiny and Assurance Manager that there have been no issues requiring their attention within the last year. As such, we have not included these committees as part of the sample testing in this audit.

Conclusion

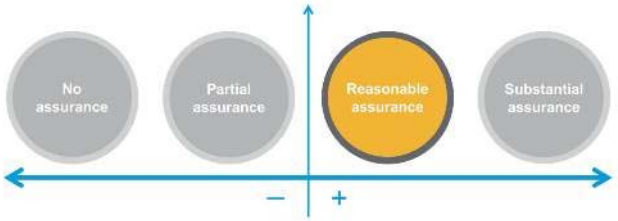
Overall, we found that the Authority's governance processes were well designed and managed, however, they have been impacted by the COVID-19 Pandemic. We confirmed that key documents were in place that provided guidance on the operation of the Authority's governance arrangements and we reviewed evidence to support these documents. However, we did identify some weaknesses relating to the declaration and management of conflicts of interests, and the regular review of documentation.

We have also identified an issue with the operation of meetings within the governance structure during the COVID-19 pandemic, with arrangements for the continuity of meetings not having been clearly put in place and approved.

Internal audit opinion:

Taking account of the issues identified, the Authority can take reasonable assurance that the controls upon which the organisation relies to manage this area are suitably designed and consistently applied.

However, we have identified issues that that need to be addressed in order to ensure that the control framework is effective in managing this area.



Key findings

Our review identified the following issues which have resulted in the agreement of two medium priority management actions:

Conflicts of interest

We reviewed the minutes for the Policy and Resource Committee meeting held in December 2019 and noted that there was a declaration made by a member in relation to a non-statutory interest (Relocation of Huntingdon Fire Station and Training Centre, as they were members of the Police and Crime Panel). We were not able to infer from the meeting minutes whether any action was undertaken to manage this conflict i.e. whether these members were excluded from the discussion in relation to where this conflict has been raised. We also reviewed minutes from the remote Fire Authority meeting held in March 2020 (conducted by Skype) and could not observe 'Conflicts of Interest' being a standing agenda item at the beginning of the meeting or whether discussions had taken place in relation to conflicts of interest within meeting minutes.

If adequate steps are not discussed and taken to manage any conflicts of interest, there is a risk that decisions may be inappropriately influenced and thus not be in the best interest of the Authority. **(Medium)**

Committee effectiveness and COVID-19 governance arrangements

The Scrutiny and Assurance Manager advised that remote Fire Authority meetings are required to assume the responsibilities of the Policy and Resource Committee and the Overview and Scrutiny Committee for as long as the restrictions of the coronavirus pandemic are in place. We noted at the time of our audit, that the Policy and Resource Committee had not met since December 2019 and the Overview and Scrutiny Committee had not met since October 2019. The Authority had initially scheduled two meetings each for both the Policy and Resources Committee and the Overview and Scrutiny Committee between the months of January and June 2020, however these were all cancelled due to the restrictions imposed by to the pandemic.

Review of the only Fire Authority meeting to have taken place during the pandemic so far (March 2020) found that this was a remote meeting held for the Chairman to consult with Fire Authority members before making decisions under his urgency powers. As such, only three agenda points were discussed at this meeting. It is therefore not clear how the duties of the Overview and Scrutiny Committee and Policy and Resources Committee have been discharged in the 2020 calendar year as meeting minutes do no demonstrate that their responsibilities have yet been assumed by the Fire Authority.

We were advised by the Scrutiny and Assurance Manager that arrangements for the merging of meetings were due to be formally agreed and be in place from June 2020. Whilst we appreciate this, there is a risk of the not being able to demonstrate a clear governance process, or inappropriate governance decisions being made. In addition, there is a risk of the organisation not achieving its objectives if key committees have not met to discharge their duties and if no interim arrangements have been put in place. **(Medium)**

Committee effectiveness pre-COVID-19

We reviewed the last three minutes for the following meetings:

- Fire Authority (June 2019, November 2019 and February 2020);
- Policy and Resource Committee (July, October and December 2019);
- Overview and Scrutiny Committee (January, May and October 2019); and
- Performance and Review Committee (October 2019, December 2019 and March 2020).

We confirmed that all four committees were broadly fulfilling their duties as per their respective Terms of References where they have met, with the following exception:

We noted that the last meetings for both the Policy and Resource Committee and the Overview and Scrutiny Committee had taken place in December 2019 and October 2019 respectively. The Terms of Reference for the Fire Authority requires the forum to review reports from the Policy and Resource Committee and the Overview and Scrutiny Committee. We noted that this has not been undertaken in the 2020 calendar year as a result of the meetings of the two committees being cancelled during the COVID-19 pandemic. We therefore noted that the Fire Authority has not been fully discharging their duties as per their Terms of Reference but have already agreed a specific action regarding this as part of the review of COVID-19 governance arrangements, above.

We have also agreed two low priority actions which are outlined further within the detailed findings section of the report.

We noted the following controls to be adequately designed and operating effectively:

Remit and quoracy requirements of Committees

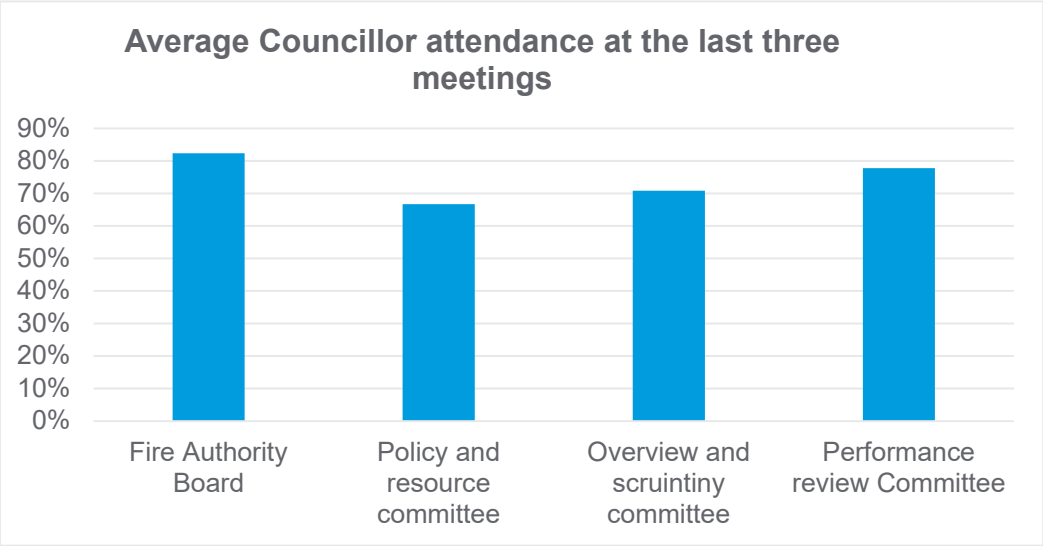
We reviewed the 'Cambridgeshire and Peterborough Fire Authority Terms of Reference' document and confirmed that it outlined the remit and membership requirements for all eight committees at the Authority. We also confirmed that the Standing Orders document outlined the quoracy requirements for all eight committees at the Authority.

Member Attendance

We confirmed that the Standing Orders stated that members in attendance at meetings must sign their name on the sheet provided for that purpose (this will revert to electronic whilst remote working). We reviewed the minutes of the following meetings across a sample of four committees as follows:

- Fire Authority (June 2019, November 2019 and February 2020);
- Policy and Resource Committee (July, October and December 2019);
- Overview and Scrutiny Committee (January, May and October 2019); and
- Performance and Review Committee (October 2019, December 2019 and March 2020).

In all instances, we confirmed that the committees were conforming to the agreed quoracy requirements as per their respective terms of references. We confirmed that the average attendance for each of these committees were 82%, 67%, 71% and 78% respectively. This has been summarised in the graphic below:



We also observed that a mixed skill set was observed of the attendees that attended these meetings.

Decisions and actions

We reviewed the last three minutes and papers for the following meetings:

- Fire Authority (June 2019, November 2019 and February 2020);
- Policy and Resource Committee (July, October and December 2019);
- Overview and Scrutiny Committee (January, May and October 2019); and
- Performance and Review Committee (October 2019, December 2019 and March 2020).

We confirmed that all four committees were using a standard structure when presenting reports that were included within respective meeting papers. Through review of each of these reports, we confirmed that a recommendation was outlined at the front page and clearly indicated where decisions were to be made. Through review of each of the above meeting minutes for each committee we confirmed that decisions were made under each standing agenda item following discussion and scrutiny by members, with members unanimously making such decisions. We confirmed that all committees reviewed their respective action logs, as well as confirming a correct record of the last meeting minutes at the beginning of each meeting.

We also reviewed minutes and the front sheet of the remote Fire Authority Skype Meeting held in March 2020 and confirmed that the details of each decision taken against each of the three agenda items discussed at the meeting were documented.

Declaration of interest

We reviewed the last three minutes for the following meetings:

- Fire Authority (June 2019, November 2019 and February 2020);
- Policy and Resource Committee (July, October and December 2019);
- Overview and Scrutiny Committee (January, May and October 2019); and
- Performance and Review Committee (October 2019, December 2019 and March 2020).

We confirmed in all cases there was an opportunity for members to declare any interests at the start of meetings and this was a standing agenda item at meetings.

2. DETAILED FINDINGS AND ACTIONS

This report has been prepared by exception. Therefore, we have included in this section, only those areas of weakness in control or examples of lapses in control identified from our testing and not the outcome of all internal audit testing undertaken.

3. Conflicts of interest			
Control	At the start of each meeting of the Authority or any of its committees/groups, attendees will be given the opportunity to declare any conflicts of interest they may have. If conflicts of interest are declared, the group will discuss whether any action is needed to be taken to manage the conflicting interests before moving on to the following agenda items. All of the groups have a standing agenda item on 'Declarations of Interests'.	**Assessment:** **Design** ✓ **Compliance** ×	
Findings / Implications 3	Policy and Resource Committee - Declaration We reviewed the last three minutes and papers for the Policy and Resource Committee (July, October and December 2019) and noted that there was a declaration made by a member in the December 2019 meeting. This was in relation to a non-statutory interest (Relocation of Huntingdon Fire Station and Training Centre as they were members of the Police and Crime Panel). We were not able to infer from the meeting minutes whether any action was undertaken to manage this conflict i.e. whether these members were excluded from the discussion in relation to where this conflict has been raised. Fire Authority meeting – March 2020 We reviewed minutes of the remote Fire Authority meeting held in March 2020 and confirmed that there were three agenda items discussed at this meeting. We confirmed that for each of these agenda items a front sheet (decision sheet) was in place, that included a section for any conflicts of interests to be declared by members. Through review of all three front sheets (decision sheets), we confirmed in all three cases that no conflicts had been declared by members. Through further review of the minutes of the remote Fire Authority meeting held in March 2020, we noted that conflicts of interest had not been a standing agenda item at the beginning of the meeting or whether discussions had taken place in relation to conflicts of interest within meeting minutes. If adequate steps are not discussed and taken to manage any conflicts of interest, there is a risk that decisions may be inappropriately influenced and thus not be in the best interest of the authority.		
Management Action 3	The Scrutiny and Assurance Manager will ensure that conflicts of interests are a standing agenda item for all remote Fire Authority meetings moving forwards.	**Responsible Owner:** Deb Thompson, Scrutiny and Assurance Manager	**Date:** July 2020	**Priority:** Medium

3. Conflicts of interest	
	When conflicts of interests are declared, the meeting will discuss whether any subsequent actions need to be taken. The outcome of this discussion will be documented within the minutes even if no conflicts are identified or no actions are required.

4. COVID-19 Governance Arrangements			
Control	A consultation meeting of members and officers of the Fire Authority was held remotely in March 2020. The meeting was held for the Chairman to consult with Fire Authority members before making decisions under his urgency powers, in these unprecedented times of living with the restrictions imposed from the coronavirus pandemic. The remote Fire Authority meeting is required to cover the remit for the Fire Authority, Policy and Resource Committee and Overview and Scrutiny Committee during this period. The Fire Authority has not formally documented and approved these remote working arrangements for meetings or the merging of any governance forums during this period.	**Assessment:** **Design**	× N/A
		Compliance	
Findings / Implications 4	The Scrutiny and Assurance Manager advised that remote Fire Authority meetings are required to assume the responsibilities of the Policy and Resource Committee and the Overview and Scrutiny Committee for as long as the restrictions of the coronavirus pandemic are in place. We noted that the Policy and Resource Committee had not met since December 2019 and the Overview and Scrutiny Committee had not met since October 2019. The Authority had initially scheduled two meetings each for both the Policy and Resources Committee and the Overview and Scrutiny Committee between the months of January and June 2020, however these were all cancelled due to the restrictions imposed by to the pandemic. Review of the only Fire Authority meeting to have taken place during the pandemic so far (March 2020) found that this was a remote meeting held for the Chairman to consult with Fire Authority members before making decisions under his urgency powers. As such, only three agenda points were discussed at this meeting. It is therefore not clear how the duties of the Overview and Scrutiny Committee and Policy and Resources Committee have been discharged in the 2020 calendar year as meeting minutes do no demonstrate that their responsibilities have yet been assumed by the Fire Authority. We were advised by the Scrutiny and Assurance Manager that arrangements for the merging of meetings were due to be formally agreed and will be in place from June 2020. Whilst we appreciate this, there is a risk of the organisation not achieving its objectives if key committees have not met to discharge their duties and if no interim arrangements have been put in place.		

4. COVID-19 Governance Arrangements				
Management Action 4	The Authority will ensure that any remote working arrangements, including the merging of any governance forums, are formally discussed, documented and approved by the Fire Authority. These arrangements will ensure that all relevant governance duties and responsibilities from the existing structure have been appropriately assigned within the revised governance structure.	**Responsible Owner:** Deb Thompson, Scrutiny and Assurance Manager	**Date:** July 2020	**Priority:** Medium

EXECUTIVE SUMMARY – PROACTIVE PROCUREMENT

Why we completed this audit

We completed an audit of Proactive Procurement to review the arrangements and systems in place to ensure that the organisation is aware in advance of any required procurements and that these are effectively planned and delivered to minimise the use of any waivers and to ensure that procurement procedures can be effectively followed.

The Procurement Team is formed of three Category Leads, each responsible for a separate area of the Service:

- Vehicles and Professional Services;
- Clothing and Operational Equipment; and
- ICT and Estates.

The Category Leads and the rest of the Procurement team meet on an annual basis in January to produce a Workplan for the upcoming financial year. The Workplan formed includes new upcoming procurement needs, contracts due (from contracts register) to expire and horizon scanning.

The Service began procurement preparations ahead of lockdown starting to ensure that required materials could be obtained when needed. A Procurement Activity Slippage Sheet has been produced to track all current and future procurement. The Slippage sheet tracks details and slippage in procurement, the impact of the slippage, the priority to address and the member of staff responsible for monitoring. As part of the audit we reviewed the Procurement section of this spreadsheet.

Conclusion

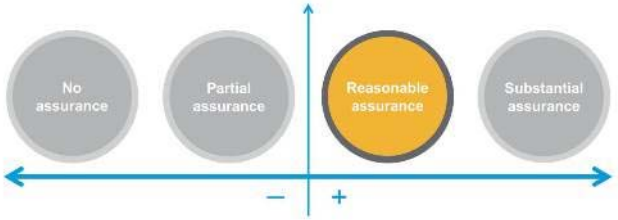
Overall, we found that the Service has in place a number of well-designed controls which demonstrate that it is taking proactive steps to ensure that procurements can be planned and undertaken in a timely manner. Examples of these controls which are operating effectively include the development of a Procurement Workplan, detailing updates on upcoming procurement and projects. We confirmed that there was active engagement between the Procurement Category Leads and Heads of Groups, which would ensure that the Procurement team has oversight over upcoming procurement requirements and is able to proactively plan resources based on these requirements. We found that procurement deadlines had been met for a sample of procurement exercises since July 2019 and supplier spend was monitored on a regular basis to identify where a contract may be required.

Our review did, however, identify some weaknesses with the design and compliance of some controls in relation to the procurement processes. We found that the procurement strategy did not include some key aspects of the procurement function and approval of the strategy had not been formally documented, slippage in procurement activities due to the pandemic had been identified but recovery plans had not yet been developed, there was no formal method of early engagement between the Programme Office and Procurement team for upcoming procurement requirements and there were no formal performance monitoring or reporting on procurement through the governance structure.

Internal audit opinion:

Taking account of the issues identified, the Authority can take reasonable assurance that the controls upon which the organisation relies to manage this area are suitably designed and consistently applied.

However, we have identified issues that that need to be addressed in order to ensure that the control framework is effective in managing this area.



Key findings

We identified the following weakness:

Procurement Strategy

The Service have a Procurement Strategy and Financial Control Standards (FCS) in place. We noted during review that whilst the FCS made reference to the completion of procurement exemptions, it did not clearly state who should approve procurement waivers. Whilst the approval limits were documented on the exemption form itself, the approval limits were not formally documented as part of any formal strategy/procedure document. We also found that the Strategy or FCS did not document potentially valid reasons for the processing of procurement waivers to provide guidance to staff and did not document guideline timeframes for undertaking procurement activities. Whilst we appreciate that most procurements will have their own timeframes, setting out minimum timeframes for the completion of key activities will ensure that there is enough time for the planning and delivering of key activities.

We were informed by the Head of Business Support, Contracts and Procurement that the Strategy had been approved by the Deputy Chief Executive, however this had not been formally documented and it had not been distributed to staff. There is a risk that staff may be unaware of the updated procedures to follow with regards to procurement if the document is not directly shared with them. There is also a risk of procurement waivers being processed due to poor planning, which should have ordinarily gone through the organisation's procurement framework. As such, we have agreed a medium priority action to include the information noted above the Strategy and FCS and to formally document approval of the Strategy and distribute it to staff. **(Medium)**

Delivery of the Workplan and COVID-19

A Procurement Activity Slippage spreadsheet has been developed documenting the impact of the slippage, priority to address and member of staff monitoring the activity. Through review of a sample of five activities we found that actions taken to address the slippage had not been recorded. Through comparison of our sample of five to the Procurement Workplan, we noted that there was no clear link between the recorded slippage and activities being undertaken by the Procurement Team. There is a risk of key tasks not taking place in a timely manner, which may result in contracts not being in place prior to the commencement of goods/service provision. As such, we have agreed a medium priority action to document recovery plans for each activity on the Procurement Activity Slippage spreadsheet or Procurement Workplan. **(Medium)**

Engaging with the Programme Office

We were informed by the Head of Business Support, Contracts and Procurement that the Procurement team would be notified of a project when it was approved, but that did not always allow for sufficient time to effectively plan a procurement exercise. We were advised that projects in the pipeline would sometimes not be communicated to the Team early enough to allow for the planning of resources within the Procurement Team. There is a risk of the Procurement Team not having the appropriate resources available to ensure procurements can be planned with enough time to be completed by the required date. As such, we have agreed a medium priority action to improve the links between the Procurement Team and Programme Office. Further detail on how to achieve this can be found in the Detailed Findings section of this report. **(Medium)**

Procurement Monitoring and Reporting

We noted through discussion with the Head of Procurement that information including procurement waivers or related key performance indicators (KPI) are not reported within the governance structure. We found that KPIs had not been developed to measure the effectiveness of procurement within the organisation. Therefore, there is a risk of inadequate oversight of procurement within the Service which could mean that issues with the performance and proactive planning of organisational procurement are not identified and remedied in a timely manner. We have agreed a medium priority action to agree procurement related KPIs and report these to an appropriate forum on an at least an annual basis. Further to this, procurement waivers will be reported to the Overview and Scrutiny Committee. **(Medium)**

We noted the following controls to be adequately designed and operating effectively:

Contracts Register

The Service has an eProcurement system in place. When contracts are due to expire notifications will be sent to the relevant procurement category lead and the contract owner. We noted during review of the contract register that it included the supplier's name, contract value and the contract owner. We confirmed through review of an example notification that contract expiry notifications had been enabled on the eProcurement system.

Procurement Workplan

The Procurement Team hold an annual procurement meeting in January to develop a Workplan for the upcoming financial year. We confirmed through review of notes taken at the meeting that it had taken place in January 2020 for 2020/21. We noted via comparison of the Workplan to the notes taken that feedback had been incorporated from the meeting, for example in relation to procurement awareness training and the new intranet site.

Engaging with Heads of Group

A Category Lead from the Procurement team is responsible for each area of the Service and liaising with that area for their procurement needs. We confirmed through review of meeting notes from April, May and June 2020 for each Category Lead that calls with Heads of Groups had taken place on a regular basis throughout the pandemic. We noted during review of the notes that topics such as upcoming exercises or contracts expiring had been discussed.

Meeting Procurement Deadlines

Procurement deadlines are set based on the procurement exercise and what is required, for example, whether it is to procure an already available product or one which will need to be custom made. We selected a sample of 16 contracts entered into since July 2019 and found in 13 cases that setting deadlines for the procurement exercises was not appropriate, for example due to the use of a framework agreement. For the remaining three, we noted in all cases that an invitation to tender with agreed timeframes had been issued in line with the deadline set. We confirmed during testing that two out of these three had been closed in their originally agreed timeframe. For the remaining one, we were informed by the Head of Business Support, Contracts and Procurement that it had been extended by one month due to the pandemic and to allow more tenders to be submitted.

Taking the extension into account, we noted during review of our sample of three contracts that in all cases the evaluation of the tender deadline had been met. We noted in one case that the contract award deadline had been met. For the remaining two, we were informed by the Head of Business Support, Contracts and Procurement that in both cases the supplier was closed due to the pandemic and as such the contract could not be awarded on time.

Procurement Waivers

A procurement waiver is approved by the Deputy Chief Executive if below £50,000 or the Chairman if above. We noted during testing of a sample of five waivers since January 2020 that in all cases reasoning had been recorded, the waiver form had been completed in full, had been signed off by the Head of Business Support, Contracts and Procurement and had been approved in line with the requirements set out on the waiver form.

Monitoring Supplier Spend

The Procurement team meets with the Finance team on a quarterly basis to review a top 20 report of suppliers by spend to identify where a contract may be required. We noted during review of the last two reports for January to March and April to June 2020 that reports had been produced for the last two quarters.

We have also identified some good practice from similar organisations which may be useful as the organisation develops key performance indicators and formal guideline reasons for procurement exemptions to be processed. Please see Appendix B for more details.

2. DETAILED FINDINGS AND ACTIONS

This report has been prepared by exception. Therefore, we have included in this section, only those areas of weakness in control or examples of lapses in control identified from our testing and not the outcome of all internal audit testing undertaken.

1. Procurement Strategy		
Control	The Authority has a Procurement Strategy document in place which is subject to approval by the Deputy Chief Executive. This approval has not been formally documented. The Strategy includes the following key information: • aims for the Procurement function; • the Integrated Risk Management Plan (IRMP); • reporting and governance; • compliance and legislation; and • procurement checklist and guidance on the process. The Strategy is supported by the Financial Control Standards, which documents the financial regulations of the organisation. These documents, however, do not clearly document procurement activity guideline timeframes, the procurement waiver approval process or acceptable reasons for procurement waivers. The Strategy is available to staff via the Service's intranet but has not been distributed.	**Assessment:** **Design** × **Compliance** -
Findings / Implications	We obtained the Procurement Strategy and noted through discussion with the Head of Business Support, Contracts and Procurement that the document had been approved by the Deputy Chief Executive however, noted that this had not been documented. We also found that the approval had not been detailed on the document itself. There is a risk that guidance available to staff is incorrect or inappropriate. We confirmed the document had been reviewed in 2018 and next review date stated was 2021. However, we noted during review of the Strategy that it did not include key information in relation to procurement, such as: • guideline timeframes for starting procurement processes or undertaking each activity, such as evaluating tenders. Whilst we appreciate that most procurements will have their own timeframes, setting out minimum timeframes for the completion of key activities will ensure that there is sufficient time for the planning and delivering of key activities; • who must approve tender waivers; and • valid reasons for tender waivers. We were informed by the Head of Business Support, Contracts and Procurement that there was a process in place for the approval of procurement waivers, and that this was documented on the procurement exemption form and the Service' FCS. Whilst we confirmed that the approval limits were documented on the exemption form itself, we noted that the approval limits had not been formally recorded in the FCS. We confirmed through review of a screenshot of the Service's intranet that the strategy had been made available to staff.	

1. Procurement Strategy				
	We were informed by the Head of Business Support, Contracts and Procurement that it had not been distributed to staff. There is an increased risk that staff will not be aware of any updated procedures and processes to follow with regards to procurement if the document is not directly shared with them. There is also a risk of procurement waivers being processed which do not comply with organisational requirements set out on the waiver form or waivers being processed due to poor planning, which ordinarily should have gone through the organisation's procurement framework.			
Management Action 1	The Service will update the Procurement Strategy and Financial Control Standards to include: • guideline timeframes for when to start a procurement process, for example one which must be advertised in the Official Journal of the European Union, and for each procurement activity, such as issuing an invitation to tender and evaluating tenders received; • the procurement waiver approval process; and • acceptable reasons for procurement waivers. Following this, approval of the document will be obtained and documented on the Strategy, for example via a signature on the cover page, and the Strategy will be shared with staff, for example via email.	**Responsible Owner:** Matthew Warren, Deputy Chief Executive	**Date:** 31 December 2020	**Priority:** Medium

2. Delivery of the Workplan and COVID-19			
Control	The Service began procurement preparations ahead of lockdown starting to ensure that required materials could be obtained when needed. A Procurement Activity Slippage Sheet has been produced to track any activities that are due to be procured or are currently being procured. The Slippage sheet tracks activities against: • the impact of the slippage; • priority to address; • member of staff responsible for monitoring; • the control measures in place; and • a link to recovery plans. No lessons learnt have been drawn from this to date.	**Assessment:**	
		Design	×
		Compliance	-

2. Delivery of the Workplan and COVID-19				
Findings / Implications	We obtained a copy of the slippage tracking sheet and selected a sample of five activities. We confirmed the nature and impact of the slippage had been recorded for all five in our sample. However, through comparison of our sample on the slippage tracking sheet to the Procurement Workplan we noted recovery plans had not been documented. As such, there is a risk of key tasks not taking place in a timely manner, which may result in contracts which have gone through a compliant procurement process not being in place prior to the commencement of goods/service provision. There is also a risk of the organisation not being able to demonstrate the proactive steps it has taken to address slippage against its workplan. We also noted through discussion that there had been regular contact with suppliers to check on their stock levels and ability to supply the Service as and when they have procurement needs.			
Management Action 2	The Head of Business Support, Contracts and Procurement will document recovery plans for each identified slippage due to the COVID-19 pandemic either in the slippage tracking sheet or Procurement Workplan.	**Responsible Owner:** Tracey Stradling, Head of Business Support, Contracts and Procurement	**Date:** 31 July 2020	**Priority:** Medium

3. Engaging with the Programme Office			
Control	There is a Programme Board in place for the Service and this has duty to look at what the organisation wants to do. Once a project has been approved, the Programme office notifies the Procurement team. Currently there is no member of the Procurement Team on Programme Board and regular updates are not received.	**Assessment:** **Design**	× **Compliance** -
Findings / Implications	We noted through discussion with the Head of Business Support, Contracts and Procurement that there is linkage between the Programme Office and Procurement team as notifications are received from the Programme Office when a project has been approved, however there are no regular updates provided on projects that may be in the pipeline. We were also informed by the Head of Business Support, Contracts and Procurement that no member from their team sits on the Programme Board. As such, where the Procurement team are not notified of projects by the Programme Office in a timely manner, there is a risk of the Procurement Team not having the appropriate resources available to ensure procurements can be planned with enough time to be completed by the required date.		
Management Action 3	The Service will improve links between the Procurement team and Programme Office, for example by implementing one of the following:	**Responsible Owner:** Matthew Warren, Deputy Chief Executive	**Date:** 31 October 2020	**Priority:** Medium

3. Engaging with the Programme Office	
	• regular catch ups between the Head of Business Support, Contracts and Procurement and the Programme Office; • a member of the Procurement team will sit on the Programme Board; or • the Head of Business Support, Contracts and Procurement will receive minutes from the Programme Board.

4. Procurement Monitoring and Reporting				
Control	Procurement information, including procurement waivers or related KPIs are not reported within the governance structure.	**Assessment:**		
		Design	×	
		Compliance	-	
Findings / Implications	We noted through discussion with the Head of Business Support, Contracts and Procurement that information including procurement waivers or related KPIs are not reported within the governance structure. We found that KPIs had not been developed to measure the effectiveness of procurement within the organisation. Therefore, there is a risk of inadequate oversight of procurement within the Service which could mean that issues with the performance and proactive planning of organisational procurement are not identified and remedied in a timely manner.			
Management Action 4	The Service will establish procurement related key performance indicators and report these to an appropriate forum(s), such as a relevant working group and the Finance Committee, on an at least an annual basis. In addition to this, procurement waivers will be reported to the Overview and Scrutiny Committee.	**Responsible Owner:** Matthew Warren, Deputy Chief Executive	**Date:** 31 October 2020	**Priority:** Medium

EXECUTIVE SUMMARY – RISK MANAGEMENT

With the use of secure portals for the transfer of information, and through electronic communication means, remote working has meant that we have been able to complete our audit. It is these exceptional circumstances which mean that 100 per cent of our audit has been conducted remotely. Based on the information provided by you, we have been able to sample test.

Why we completed this audit

An audit of the Risk Management processes was undertaken as part of the Internal Audit Plan 2020/21. The review was undertaken to assess the arrangements in place including the Strategic Risk Register (SRR) and the identification and escalation of risks through the organisation.

The Service have a SRR in place to record risks, issues and opportunities, which as of Version 39 updated on the 4 August 2020, included 90 items, of which 72 are defined as risks, two are defined as issues and 16 are recorded as opportunities.

For each risk on the register, the inherent risk score, current risk score and post mitigation score are recorded, based on a 5x5 risk matrix, categorising risks as very low to very high. Numbers are calculated by multiplication of the probability of a risk occurring against the impact it would have if it did occur. High and Very High Risks (those scored from 10-25) are required to be reported on to the Policy and Resource Committee.

In support of the risk scoring, the SRR is required to record the controls currently in place for each risk, as well as the planned mitigation to enable the post mitigation score to be achieved.

The Head of Service Transformation is the main point of contact for risk management at the Service and updates the SRR on a quarterly basis following discussions with each of the risk owners in addition to as when and needed. The timeliness of reporting and review of the SRR was affected as a result of the pandemic, however, this has returned to normal as of July 2020.

The Service's Integrated Risk Management Plan (IRMP) supports the risk management, with actions included as part of the IRMP developed from risks identified in the SRR, with progress on these actions reported to the Chief Officer's Advisory Group (COAG) quarterly.

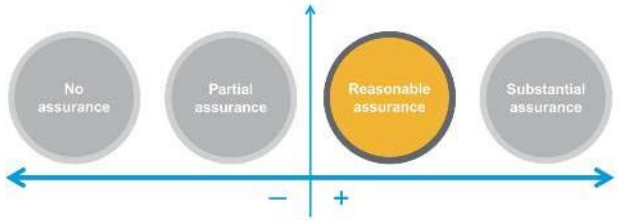
Conclusion

We identified that the Service has a Strategic Risk and Opportunity Management Plan in place, updated in July 2020, along with risk management training material for members of staff. Furthermore, we noted that the SRR had been set up to collect relevant information for each risk, including the controls, mitigation activities, risk scoring and risk owners. We additionally noted that risks included on the register were updated regularly, albeit with a slight delay as a result of the COVID-19 pandemic.

We, however, identified weaknesses in controls during the audit, including a lack of updating to the Business Delivery Risk Register which is utilised for the updating of risks that may adversely affect the day to day delivery of operations, we found this had not been updated for the majority of its risks since May 2019. We additionally identified weaknesses in evidencing risk identification and escalation, as well as a gap in the reporting to the Policy and Resources Committee. Further issues related to linkages for updates between the SRR, project risk register and programme risk register, and tracking completion of risk management training.

Internal audit opinion: Taking account of the issues identified, the Authority can take reasonable assurance that the controls upon which the organisation relies to manage this area are suitably designed, consistently applied.

However, we have identified issues that that need to be addressed in order to ensure that the control framework is effective in managing this area.



Key findings

We identified the following weaknesses:

Strategic Risk Register Scores

We selected a sample of 10 risks and confirmed that in all cases the risk scores had been completed for inherent, current and post mitigation. We confirmed in six cases that the reduced scores made sense based on the controls and mitigations in place. However, we noted the following exceptions for our sample:

- In one case the risk score had not been calculated correctly, although this would not have made any difference to its reporting requirement as it would still be presented as a very high risk;
- In two cases the risk score impact had reduced from inherent to current, however there was insufficient information provided to explain how this had occurred;
- In one case, mitigation had been completed for the risk, however the current risk score had not reduced from the inherent risk score and had not achieved the post mitigation score. No further information had been included for the mitigation of this risk; however, we were informed that the risk was required to be monitored further.

There is a risk that if risk scores do not accurately correspond to the current status of the risks, appropriate oversight may not be provided. Additionally, risks may not be sufficiently mitigated to ensure their probability of occurring is appropriately reduced. **(Medium)**

Business Delivery Risk Register

Through review of the Strategic Risk and Opportunity Management Plan, we noted that the escalation of risks to the SRR would not be based solely on scoring, with escalation undertaken as a result of discussions between the Heads of Group, which is not currently evidenced. The Heads of Groups discussions include review of the Business Delivery Risk Register, to escalate risks that may adversely affect the day to day delivery of the operational response or service delivery.

Through review of the Business Delivery Risk Register, we noted that the document had a last updated date of 10 May 2019. Whilst we noted that five out of the 75 risks included on the register had an updated date of 5 August 2020, no comment had been provided against them.

The remaining 70 risks had not had an update since 2019, with 11 not having been updated since 2018. There is a risk required monitoring and management of the Business Delivery Risk Register has not been undertaken, and as a result risks have not been appropriately managed, and where required escalated. **(Medium)**

Risk Identification

We confirmed through review of the Strategic Risk and Opportunity Management Plan that risks identified are to be informed to the Head of Service Transformation. We noted that risk identification is not currently a standing agenda item on meeting minutes for the Policy and Resources Committee or Chief Officers Advisory Group, and currently the Heads of Group meetings do not have minutes taken. We found that risk identification is to take place at annual workshops, however, this has not been undertaken since April 2019. Additionally, with training not presently mandatory, there is a risk that there is not sufficient awareness of the processes for undertaking risk identification, and as a result new risks may not be identified and appropriately mitigated. **(Medium)**

Policy and Resources Committee

We identified through review of the last three meeting minutes for the Policy and Resources Committee that these had taken place in April 2019, September 2019 and June 2020. We were informed by the Head of Service Transformation that the committee were intended to meet quarterly, however, at present this was not documented. We noted that group had an eight month gap in reporting between September 2019 and June 2020. Although the pandemic may have affected this gap in reporting between March and June 2020, we were not provided with any reason for the lack of meetings between September 2019 and March 2020. As the group is a key location for the review of risks on the SRR, there is a risk that the required oversight has not been provided. **(Medium)**

We noted the following controls to be adequately designed and operating effectively:

We obtained the Service's Strategic Risk and Opportunity Management Plan and confirmed that it had last been reviewed and issued on 20 July 2020. Through review of the document we confirmed that the plan documented the risk appetite as accepting any very low to medium level risk, stating that reporting is required for any risk assessed as high or very high. We confirmed that guidance was additionally provided for the scoring approach, including the definitions of what is considered Very Low to Very High risk and the use of the scoring matrix, methodology and scoring criteria, along with guidance over committee responsibilities for risk.

We obtained the Service's training documents, including a presentation for project managers, a presentation on risk management for relevant staff, as well as slides from the risk management training module and confirmed that appropriate guidance had been produced aligned to the Strategic Risk and Opportunity Management Plan, including the approach to wording a risk to capture cause and effect, the risk scoring grid as a guide, and risk owner information.

We obtained the Service's SRR, version 39, last updated on 4 August 2020. We noted that the register contained aspects stated as Risks, Opportunities and Issues.

Through review of the risks recorded on the register, we confirmed that:

- the register was designed to capture the description of the risk, in which a standardised approach to writing was used to detail the cause, effect and consequence of the risk;
- the register included controls, mitigation activities (including completion dates), and updates;
- the register detailed inherent risk scoring, pre mitigation risk scoring (Current Score), and post mitigation risk scoring, as well as defining what each meant to increase its ease of use.
- the register included a location to record risk owners and action owners

We additionally discussed with the Head of Service Transformation how assurances are taken with regards to the management of the risks. We were informed that as actions assigned to risks are completed these would be moved across to the control section. This would only be carried out by the Head of Service Transformation upon confirming that the actions had been completed as expected. These can vary in type of assurance but are only moved once this is received. The formal documentation of assurances has been raised previously however, due to the varying nature and type of assurances both formal and informal, the organisation does not consider it a requirement to record these within the register.

We selected a sample of five projects currently in progress at the Service and confirmed that in each case an individual project risk register had been produced, which was in the same format as the SRR. The project risk register design currently does not include inherent risk scoring which we were informed by the Head of Service Transformation was to keep it simple for those users. We confirmed that the Business Delivery Risk Register and Programme Risk Register followed the same approaches.

We confirmed through review of the SRR using a sample of ten risks, that in nine cases the risks had been reviewed most recently in July 2020 with updates provided. In the final case, we found that there was no update provided, but it had been recorded as reviewed. We noted that prior to this review, the last formal update was prior to COVID-19 between January 2020 and April 2020. We were informed that any delays in the quarterly updates was as a result of the COVID-19 pandemic making it harder to arrange one to ones. Through review of the updates recorded in the SRR we confirmed that updates were recorded each time the risk had been reviewed for each risk presented, and related to updates to mitigating actions, risk scoring, and general updates on the risk.

Through review of the last three Policy and Resources Committee meeting minutes, we confirmed a detailed review of the risks presented in the report were discussed, along with queries and scrutiny provided. Through review of the reports presented we confirmed that in each case the very high and high risks were presented in each report, with updates provided on each one.

2. DETAILED FINDINGS AND ACTIONS

This report has been prepared by exception. Therefore, we have included in this section, only those areas of weakness in control or examples of lapses in control identified from our testing and not the outcome of all internal audit testing undertaken.

Strategic Risk Register – Deep Dive				
Control	The Service have a SRR in place, documenting the key risks and opportunities faced by the Service and detailing the inherent, current and post mitigation score including the intended mitigation planned to reduce the risk score.	**Assessment:**		
		Design	✓	
		Compliance	×	
Findings / Implications	We selected a sample of 10 risks from the SRR to confirm that they had been recorded with appropriate detail and information. In all ten cases we confirmed that risk scores for inherent, current and post mitigation had been completed. In six cases we confirmed that the risk scores were calculated correctly, and that the reduced scores made sense based on the controls or mitigations in place. However, we noted the following exceptions: • In one case the risk score had not been calculated correctly although this would not have made any difference to its reporting requirements as it would still have been recorded as a very high risk; • In two cases the risk score impact had reduced from inherent to current, however based on the control information it was not clear why this was appropriate; • In the final case all mitigation had been completed for the risk, however the current risk score had not reduced from the inherent risk score and was not aligned to the post mitigation score. This is despite no further mitigation being in place. We were informed by the Head of Service Transformation that this risk would be continually monitored, however nothing has been documented on the register. There is a risk that if risk scores do not accurately correspond to the position of risks, appropriate oversight may not be provided as they are scored incorrectly. Additionally, risks may not be sufficiently mitigated to ensure their probability of occurring is appropriately reduced.			
Management Action 3	We will review risk scores included on the Strategic Risk Register and confirm that they are: a) correctly calculated including the use of formula to avoid manual errors; and b) appropriately scored for probability and impact based on the control and mitigation information, including any justification for the reduction of impact scores.	**Responsible Owner:** Head of Service Transformation	**Date:** January 2021	**Priority:** Medium

Business Delivery Risk Register				
Control	The Service have a Business Delivery risk register in place, with the Business Delivery Groups required to meet quarterly prior to the Chief Officers Advisory Board meeting to review. At the meeting, the current status of risks will be reviewed as well as identifying any escalation required. These meetings are not currently minuted. The Business Delivery Risk Register follows the same format as the SRR, save for the inclusion of inherent risk scoring.	**Assessment:** **Design** **Compliance**	 × N/A	
Findings / Implications	Through discussion with the Head of Service Transformation and through review of the Strategic Risk and Opportunity Management Plan, we noted that the escalation of risks to the SRR would not be based on scoring and would be carried out as a result of discussions between the Heads of Group, which is currently not evidenced. Despite risks present on the register being scored as high or very high we were unable to identify that risks had been escalated onwards to the SRR, as risk numbers were recorded as per the risk register held on. There is a risk as a result that sufficient consideration of the escalation of risks to the SRR has not been undertaken. Through review of the Business Delivery Risk Register, we noted that the document had a last updated date of 10 May 2019. We noted the latest update against any of the risks was 5 August 2020, representing five out of 75 of the risks, however no comment update had been provided for them. We noted that in 11 out of 75 cases a review of the risk had not been provided since 2018, and throughout the register aspects such as date identified, mitigation activities, target and action owners, and post mitigation scoring had not been completed. There is a risk that the required monitoring and management of the Business Delivery Risk Register has not been undertaken, and as a result risks have not been appropriately managed, and where required escalated. We noted a reminder had been distributed to those involved with the Business Delivery Register to ensure quarterly review, however this had not commenced as of the audit.			
Management Action 4	We will ensure that the Business Delivery Risk Register is reviewed on a regular basis, with updates provided as required and evidenced as such. We will consider whether appropriate escalation processes are in place for risks on the Business Delivery, Programme and Project risk registers.	**Responsible Owner:** Head of Service Transformation	**Date:** January 2021	**Priority:** Medium

Risk Identification			
Control	Risks identified at an operational level are required to be recorded on either the Project Risk Register, Programme Risk Register or the Business Delivery Risk Register, and where relevant the SRR. A Business Delivery Risk is defined as an event or situation that may adversely affect the day to day delivery of the operational response or service delivery. The risk register could be added to following standard meetings, or through notification of risks to the Head of Service Transformation. Risk identification is not presently a standing agenda item on group agendas. A Programme Risk is defined as an event or situations that may adversely affect the direction of the programme, the delivery of outputs or expected benefits realisation. The risk register would be added to throughout the programme life. A Project Risk is defined as an event or situation that may adversely affect the direction of the project, the delivery of outputs or benefits realisation laid out within the agreed Project Brief/Business Case. As with the programme risk register, the project's risk register would be added to as and when risks were identified by the lead.	**Assessment:** **Design**	✓ ×
		Compliance	
Findings / Implications	We confirmed through review of the Strategic Risk and Opportunity Management Plan that risks identified are to be notified to the Head of Service Transformation. We noted that the Strategic Risk and Opportunity Management Plan notes that strategic risk workshops will be conducted with COAG on an annual basis in September of each year, and confirmed that this had taken place in April 2019, with the upcoming review included on the agenda for October 2020. Through review of the April 2019 meeting, we noted that a risk refresh had been undertaken for all risks included on the programme risk register, SRR and Business Delivery Risk Register, including reassessment and addition of two new risks. We noted that with this last undertaken in April 2019, and the next due for October 2020, there is a risk that there has not been sufficient oversight undertaken in a timely manner against the requirement of annual review. We noted that risk identification is not a currently a standing agenda item on the meeting minutes for the Policy and Resources Committee minutes, nor the Chief Officers Advisory Group. The Business Delivery Group are also required to identify risks as part of their meetings, however, these are not currently minuted, and as a result we were unable to identify the approach taken in these meetings. As observed above, training is not presently mandatory for staff, which may as a result mean that risk identification processes are not well known by key staff. There is a risk that without a clear process for the recording of risk identification in place, it may not be undertaken, and as a result, risks may not be managed and mitigated. We confirmed through review of the SRR that regular meetings with risk owners was undertaken, however there was no way to evidence discussion with regards to arising risks. We did note that there were new actions identified during February and March 2020, however it was unclear through what process these were added to the register.		

Risk Identification				
Management Action 6	We will ensure that: • The annual review at strategic risk workshops for escalation and identification of risk is undertaken in a timely manner; • Relevant staff have been made aware of the appropriate process; • A standing agenda item for new and emerging risks is included for relevant meetings. This will include ensuring that risk owners are liaised with for arising actions.	**Responsible Owner:** Head of Service Transformation	**Date:** May 2021	**Priority:** Medium

Policy and Resources Committee			
Control	The Policy and Resource Committee receive a report of the high and very high risks on a quarterly basis to allow for challenge of those risks. There is currently no single group that undertakes a full review of the SRR.	**Assessment:** **Design** **Compliance**	 ✓ ×
Findings / Implications	We obtained the Policy and Resources Committee terms of reference and confirmed that the requirement to review the SRR was a responsibility, although not defined as to what exactly the group would review. We noted that the membership was detailed, however there was no details on the required regularity of meetings. Through review of the last three meetings, held in April 2019, September 2019, and June 2020, we noted that there was a lack of regularity in the meetings, which we were informed by the Head of Service Transformation should have been quarterly. Although COVID may be responsible for the lack of reporting between March and June 2020 we were not provided with the reason for the lack of meetings from December 2019 to March 2020. As a result, there is a risk that required oversight has not been provided of the SRR.		

Management Action 7	We will ensure that four updates are provided every year to the Policy and Resources Committee, ensuring that the strategic risks are reviewed.	**Responsible Owner:** Head of Service Transformation	**Date:** September 2021	**Priority:** Medium

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